CREATING A HEALTH SYSTEM WITH ZERO PERCENT GBV

LESSONS FROM THE MEADOWLANDS CLINIC PILOT PROJECT

A PILOT MULTI –ACTOR, COLLECTIVE IMPACT, ACTION LEARNING APPROACH TO ADDRESS GBV IN THE HEALTH SYSTEM – SUPPORTED BY THE JOINT GENDER FUND AND OXFAM SOUTH AFRICA



FOREWARD

In February 2015 the Labour Research Service (LRS) and Gender at Work in partnership with the trade union HOSPERSA initiated a pilot social action project at the Meadowlands Clinic in Soweto, Gauteng. The intention of the project is to experiment at a local level and in one locality, with bringing together the different actors involved in the health system i.e. all the providers as well as beneficiaries – to take up actions that will collectively impact on reducing the high levels of gender based violence in the Meadowlands Clinic.

As a pilot project, the intention is for the LRS, Gender at Work, HOSPERSA and the actors involved in the social action experiment, to share what we are learning in a way that inspires and supports efforts to address gender based violence in the health system more broadly.

Our health services play a crucial role in responding to gender based violence and protecting women's health and rights. For a survivor of gender based violence, the health care worker at a clinic or hospital is most likely to be one of her first points of contact.

Health care workers can also play an important role in raising awareness in communities as regards the long term health implications of gender based violence - physically, emotionally and psychologically.

Our challenge is that the health care worker in public health institutions, the majority of whom are women, might herself experience high levels of workplace violence. Conditions in the health facilities like staff shortages; physical infrastructural challenges like the lack of ventilation, inadequate basic services like water and electricity; the lack of support programs in dealing with stress and emotional and psychological trauma; the increasing risk of contracting communicable diseases; high levels of social instability in many communities and the impact this has on the safety and security of health care workers and more generally the precarious, low-paid, low status of health care workers - all contribute to creating a working environment where health care workers report feeling violated, abused, undermined and devalued.

This sense of violation and abuse is often not recognized or acknowledged by the patient or broader society and the health care worker is expected to remain caring and sensitive to the needs of patients regardless of her working environment and conditions. More often than not a health care worker's experience of the public health system is highly gendered – entrenching the stereotype that care work is women's work and that women's work is less valued when compared with what is perceived as men's more "productive" work.

Through the pilot project in the Meadowlands Clinic we are finding that this volatile mixture of gender based violence survivors seeking health care support and finding angry, disillusioned health care workers working under unsafe and hostile conditions - is a major obstacle in responding to gender based violence.

Our goal is not to see the pilot project in the Meadowlands Clinic replicated as a formula for reducing gender based violence in the health system – but rather as a sharing of insights and lessons between people committed to a health system free of gender based violence.

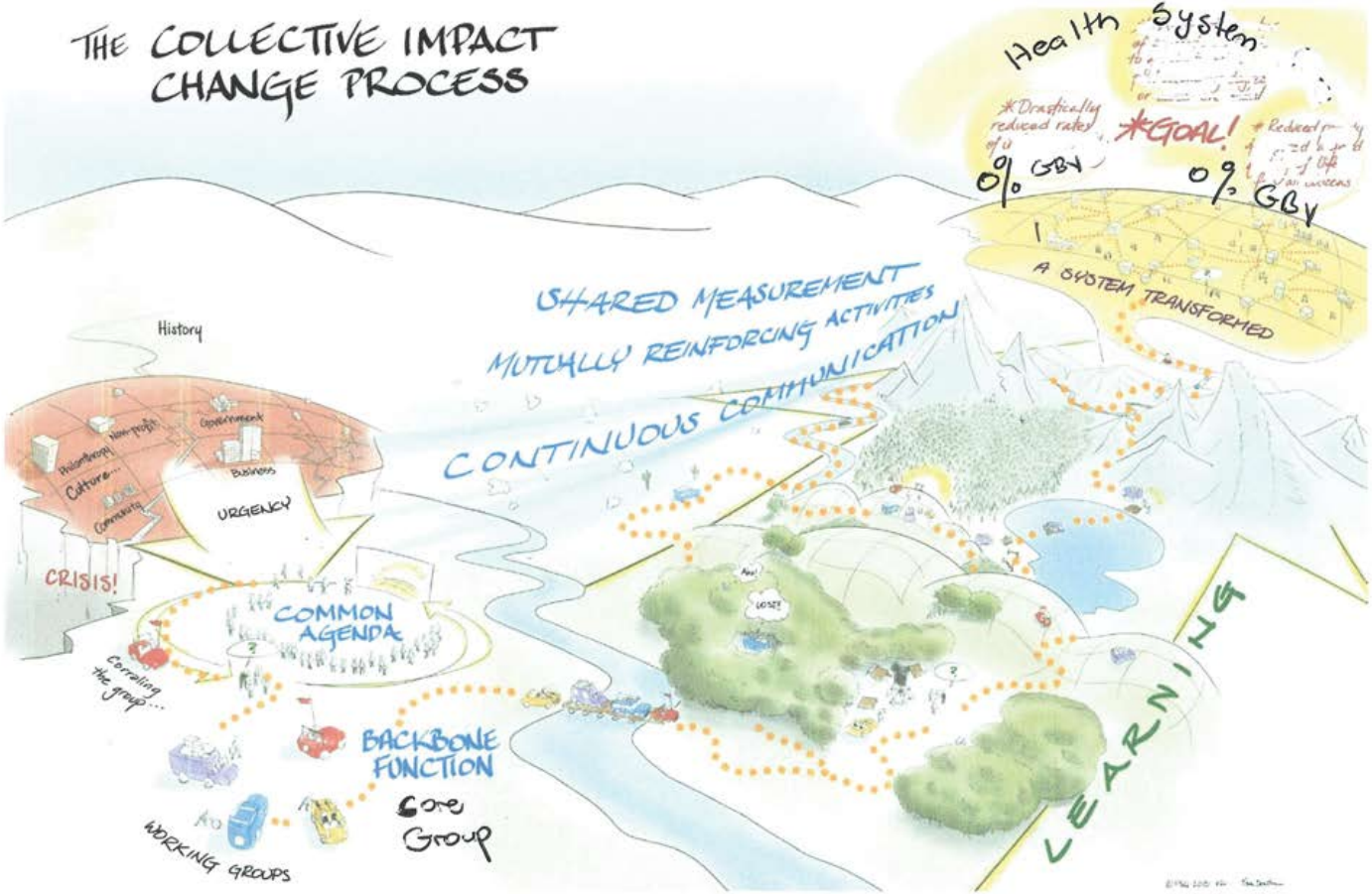
FACILITATING A COLLECTIVE IMPACT PROCESS

In 2012, HOSPERSA had been a participant in a LRS - Gender at Work led Gender Action Learning process where HOSPERSA participants shared their concern about the high levels of GBV in the health system and how particularly the voices of nurses were not being heard. The discussions prior to the implementation of the Meadowlands Clinic pilot project raised the urgency of addressing both the rising levels of violence and the silence of health care workers.

Since the end of 2013 as LRS and Gender at Work facilitators we have been fortunate to be part of a feminist inspired social change experiment that supports individuals and organisations in the Vaal. Under the banner of Letsema community members have a common vision and shared strategies and actions for creating 0% gender based violence in the Vaal. This common vision and shared strategies and actions is emerging through dialogues involving a diverse group of community members and groups. The different actions, driven by the commitment and passion of the community members is at the heart of Letsema's attempt at reducing gender based violence in the Vaal.

We are framing our approach in Letsema as a "collective impact approach".

Collective Impact is the commitment of a group of actors/stakeholder from different sectors - to a common agenda for solving a specific social problem, using a structured form of collaboration. Solutions are co-created from the lived experience of all the actors/stakeholders involved.


THE COLLECTIVE IMPACT CHANGE PROCESS
Health System
*Drastically reduced rates
*GOAL!
0% GBV
0% GBV
A SYSTEM TRANSFORMED
SHARED MEASUREMENT
MUTUALLY REINFORCING ACTIVITIES
CONTINUOUS COMMUNICATION
History
Philanthropy
Non-profit
Government
Business
Culture...
Community
URGENCY
CRISIS!
COMMON AGENDA
Corraling the group...
BACKBONE FUNCTION
Core Group
WORKING GROUPS
LEARNING

Inspired by Letsema's use of the collective impact approach we began to explore the possibility of experimenting with similar processes in the health system. The idea was to work in a way that inspires members of the various stakeholder forums in the health system to commit themselves to work with trust, in a respectful, non-judgmental way - to experiment both individually and collectively with actions that contribute to a health system free of gender based violence.

Creating meaningful engagement towards a collective impact in a context that can be fraught with tension, power struggles and lack of resources - is the challenge we set ourselves with the Meadowlands pilot project.

A SENSE OF URGENCY AND A WILLINGNESS TO EXPERIMENT

In November 2014 LRS facilitators Nina Benjamin and Nosipho Twala and Gender at Work facilitator Fazila Gany met with HOSPERSA officials and representatives from 9 health institutions where they shared their experiences of gender based violence in the 9 institutions. With a great deal of emotional pain, health care workers spoke about the high levels of verbal, physical, psychological and sexual abuse both patients and health care workers experience in health facilities. For the health care workers there was a sense of desperate urgency to find ways of addressing the high levels of violence in health institutions.

This story from Baby Moipone Ntoula, a nurse clinician and HOSPERSA shop steward at the Meadowlands Clinic illustrates the challenges faced by health care workers.

Baby Moipone Ntoula

We had this Wednesday group. We give people time to come – i.e. Monday to Friday. With this Wednesday group –when I knew that this group was coming I felt like not going to work and you won't believe – I am talking about elderly people, not peers, not young people!

These people from the Meadowlands community used to terrorise us. From the time that they come into the gate they start singing songs because they said our services are so poor and that we don't care for them. We take our own time, we go for lunch for 3 hours and leave them unattended. We go for tea for hours on end. When we come in they will be singing, you could not get a glass of water because the minute you leave your station they start singing. They said we are going to burn this clinic down with you guys inside. This came from our mothers and fathers not from our peers. Sometimes you forget to be professional. If it is somebody younger than you will talk like a mother. If it is your peer you will just talk BUT if it is your mother, father, Granny – it is another story. We did not take this lying down because if they say you are going to be burnt in the clinic and they have done it somewhere, not at Meadowlands community but somewhere else, it is serious.

Everyone agreed that the challenge was complex and that while stories of patient abuse at the hands of health care workers feature prominently in the media, very little is being said about the cycle of abuse between patient and health care worker at health institutions. For the health care workers in the meeting their safety and security, sense of dignity and professional identity were being ignored, devalued and abused by both the community they served as well as by the Department of Health. Yet, they also recognised that for the community they appeared uncaring and unwilling to address the needs of patients.

Throughout the HOSPERSA consultative workshop a sense of urgency prevailed but at the same time everyone recognized that there was no quick fix, no one organization, no one policy or any single intervention that can reduce the levels of gender based violence in the health system. Using the collective impact approach we identified "patient urgency" as key to moving forward. As facilitators this would mean exercising patience by holding the process in a way that allowed moments of chaos and tension to prevail, supported stakeholders to experiment with new ideas or to rethink existing strategies and create a space for everyone's voice to be heard and respected– while maintaining a sense of urgency. Working with limited and time bound resources we agreed that for the process to be truly effective we would experiment in one local health institution – and then share the experience and results of the experiment. Meadowlands Clinic in Soweto was chosen as the experiment.

The Meadowlands Clinic is a government primary health care facility with a community oriented primary health care program that monitors and proactively works towards the improved health and wellbeing of families in the Meadowlands area. One of the services the Clinic provides is counselling before referring survivors of abuse and rape for further assistance.

Creating a core group to guide the process

From the onset HOSPERSA recognized that guiding the process would need to go beyond the trade union. Baby Moipone Ntoula, the HOSPERSA shop steward driving the process at Meadowlands Clinic took on the responsibility of inviting key stakeholders in the clinic to be part of initiating the pilot project.

“For me the idea of the pilot project was a way to deal with all of the tension in the clinic - all the angry emotions and violent outbursts - but I knew that it would be a daunting task. Knowing that it was going to be a team effort helped. The first person I spoke to was the chairperson of the Clinic Health Committee (CHC) Alice Hoskins, and then to two other members of the CHC Martin Dibodu and Chris Tselane - who were all very interested in being part of the project. I also approached the clinic manager. At first it was difficult explaining why this was a project dealing with gender based violence. As staff in the clinic we have the responsibility of supporting survivors of gender based violence but explaining that as staff we were also both perpetrators and victims of gender based violence was very difficult. I had to explain why the work we are doing as health workers puts us in a very vulnerable position where we are expected to care for everyone and suffer all forms of abuse but remain silent.

We started in February 2015 with a meeting of representatives from the 4 unions in the clinic i.e. HOSPERSA, DENOSA, NEHAWU and PSA as well as the members of the Clinic Health Committee. As a nurse in the clinic my first challenge was to find the time to participate in the meetings – as this meant I would have to leave patients so as to be part of the discussions. It was also challenging to convince my fellow staff members of the benefits of the project but the members of the Clinic Committee played a key role in explaining how the project could begin to address some of the tension between staff and patients.

The understanding of the value and role that the project could play got better after the clinic committee addressed the issues. We are short staffed, although there is a tool that says that we are over staffed, we are not and this places a great deal of tension on the staff – so if someone is not attending patients the rest of the staff are angry and frustrated. As the project unfolded and staff began to see relations in the clinic improve I have been able to attend all the meetings with the blessing of my colleagues”

CREATING A COMMON AGENDA

In March 2015 the trade unions and Clinic Health Committee organised a broader workshop that included members of the SAPS (FES unit); representative from the Regional District Health Forum; Lifeline; Meadowlands Care for the Aged; People's Health Movement; : Rhema Church, Methodist church; Vuka Mama; Sonke Gender Justice and Brothers for Life and the civic structure, SANCO. Using the Collective Impact Approach we started by looking outward and asking ourselves "what is the change we want to collectively create?" With this question we encouraged all stakeholders to contribute to a common agenda and through this process the framing question for the pilot project emerged: ***"What will it take to create 0% GBV in the Meadowlands Clinic?*** The framing question focuses on releasing a sense of creativity in taking up the challenge of reducing the levels of gender based violence in the clinic and is based on the assumption that every stakeholder and individual can contribute.

The discussions in the first workshop presented the baseline landscape, detailing the extent of the levels of violence in the clinic and identifying **inadequate forms of communication** at all levels of the health system and **the imposition of rapidly changing policies**, as two of the key factors fueling the levels of gender based violence in the Meadowlands Clinic and in the health system more generally. The March 2015 Workshop saw the broadening out of the core group to include the church, Global Care Centre, SAPS, People's Health Movement and Regional District Health Forum.

The core group with the support of the facilitators forms the backbone of the pilot project and as the name suggests the functions of the core group includes working with the framing question to guide the vision of the project, engaging respectfully and honestly with stakeholders and influential individuals, creating safe spaces for dialogue, mobilising resources for activities and having a continuous process of reflection and evaluation that guides the direction of the project.



Members of the Meadowlands Clinic Core Group

- Baby Moipone Ntoula is a nurse clinician and a Hospersa shop steward at Meadowlands Clinic
- Alice Hoskins is a Meadowlands Clinic Health Committee member, Deputy Chairperson of the District Health Forum and Chairperson of the Ward Committee
- Christopher Tshelane is the chairperson of a local SGB and a member of the Clinic Health Committee
- Gift Nyiko Lubisi is a youth coach, inspirational speaker and works in the field of trauma counselling
- Martin Dibodu is a local businessman, church leader and a member of the Clinic Health Committee
- Modibalotsile Joseph Phetoe – executive member of the Community Policing Forum (CPF) and church bishop
- Shadrack Sebusi – President of preachers and initiator of the Wellness Club
- Edna Bokaba – retired nurse, board member of LGBT organization and serves in the area of social justice with Methodist Care Centre
- Falatsi Mphuti – Chairperson of Region D District Health Forum
- Phumzile Mashishi – project officer at HOSPERSA and served as Vice Chairperson for FEDUSA social Justice Committee
- Margaret Motau – Clinic Health Committee Member

How the core group functions

Our experience as facilitators has taught us that both the physical environment as well as how participants enter or leave the space is key to creating trust and a sense of ownership of the process. The core group meets at least once, sometimes twice a month at the Meadowlands Clinic. The clinic is very busy so at times we are only be able to meet after lunch. Our meetings take place in whatever space is available in the clinic at the time. With the limited time and space available it is important that as facilitators we create an environment that is inviting, relaxing while keeping the urgency and focus of the discussions. We start the session with a light tea where everyone is able to check in informally and then engage in a set of tai chi movements based on Tai Chi Chih, developed by Justin Stone. With everyone rushing in, still very preoccupied with the daily challenges of work and life and at times carrying deep levels of trauma from the abuse being experienced in the workplace, home or community - the tai chi movements helps us to release stress and let go of tension, negativity and body pain and supports us in feeling more alert, present and focussed. As the core group members experience the benefits of feeling calmer and more present in discussions, they have begun to practice the tai chi exercises individually but also with the groups of people they interact with on a daily basis.

While the core group includes stakeholder representation – each of the persons participating are not carrying out a mandate but are individually committed and passionate about the process of reducing the levels of gender based violence in the health system. Gift Lubisi a young woman from the Global Care Centre illustrates this when she speaks about her reason for joining the core group:

> *‘I didn’t like nurses since every time I would go to the clinic, I felt like everybody was angry. Before when I went to the clinic it was because it was my last resort and I asked myself why is the one sector that is supposed to help me, a place that I try at all costs to avoid’*

Different kinds of Leadership; Diversity and Inclusion

Leading and guiding is often associated with a charismatic, influential leader that brings others to the table – and for the start of the process the HOSPERSA shop steward at the Meadowlands Clinic, Baby Ntoula played that role, but as the core group coalesced different types of leadership emerged, more adaptive, inclusive and collaborative forms of leadership where we focused on treating each person and each stakeholder's contribution as equally valuable. Building trust as an intentional effort has been key to this process and this has meant we have had to create space to share not only our different ideas and strategies for change, but also to speak honestly about our motivations, interests, concerns and leadership styles. This has not been without tension. Working as group where the oldest member is in her 80's and the youngest in her 20's, where both self-proclaimed "traditional" men sit alongside women who identify as feminists and where members in the group have been challenged to address homophobic attitudes and beliefs – has not been easy, but everyone has understood that if our goal is inclusion then working with diversity is important. Being willing to show vulnerability with people you trust is also going a long way in assisting core group members recognize and challenge gender power relations between men and women, young and old and people with different sexual orientations and gender identities. Falatsi Mphuti, the chairperson of Region D District Health Forum, speaks openly about challenging his own sense of what it means to be a man:

> *'I cannot just say I am a traditional man and just stay a traditional man. I am conservative and a traditionalist but I am becoming more open to the issues of gender. Since this process started I am changing as a person but I realised that it is not enough to say culture is outdated, I need to be changing myself.'*

Conflicts and differences of opinion amongst core group members will continue to exist as long as the group functions – but the group has managed to remain with the trust that everyone participating in the core group is committed to the common vision of 0% gender based violence.

Falatsi Mphuti



Community engagement

A key function of the core group is community engagement. The core group's strategy is to focus on the creation of safe spaces for dialogue where all community members and groups concerned about the high levels of gender based violence in the Meadowlands Clinic have been invited to express their feelings and understanding of the crisis and to share the kinds of contributions they can make in reducing the levels of gender based violence in the clinic. The community dialogues posed important challenges for the core group. Community members often came to the dialogues to raise complaints and even to vent their anger at Clinic staff, clinic staff to vent their anger at the Department of Health etc. – all potentially leading to a cycle of blame and anger. Using their experience of core group meetings the core group worked hard to create a welcoming space free of judgment while constantly reminding themselves and those participating in the dialogues of the framing question and common vision. It has also taken many discussions, reading, and reflection for core group members to feel comfortable explaining to community members why much of the violence being experienced in the Clinic is gendered and why it is important to recognize it as gendered if one is to change the way care-giving is not only devalued but becomes an arena for gender based violence – noting the emotional, psychological and at times even physical abuse that both patients and health care workers experience.

Phumzile Mashishi
A Hospersa Project Officer

PLANNING DIFFERENT ACTIONS FOR COLLECTIVE IMPACT

In the first meetings of the core group there was an agreement that while Baby Moipone Ntoula's story about the levels of anger, frustration and violence at the Meadowlands Clinic, was a subjective account of her experience as a staff member at the Clinic, it did echo the sentiments of other actors in the project and was a summary of the complex nature of reducing the levels of gender based violence in the clinic. Baby's story together with written quotes from participants in the first community workshop in March 2015 – raising very similar scenarios, then became our **baseline**.

Our next step was to develop a set of hypothesis or questions that the core group aimed to test. As different actors/stakeholders, each member of the group had different priorities as well as different ideas on possible solutions. The process of developing the hypothesis offered all actors/stakeholders the possibility of testing out actions from their vantage point – while recognizing that they are all contributing to the common agenda of "creating 0% GBV in the Meadowlands Clinic". Some examples of hypothesis that were tested are the following:

"What will it take to get the Meadowlands Clinic Staff more involved in creating 0% GBV in the Meadowlands Clinic?" was the question preoccupying the trade union members who are concerned about the "culture of silence" amongst health care workers. The HOSPERSA planning discussions had revealed that health care workers and particularly nurses very seldom reported cases of abuse with many of the nurses expressing a sense of resignation and inability to prevent the abuse they felt they experienced at the hands of the community and the lack of understanding and support from the Department of Health. Phumzile Mashishi, a HOSPERSA official felt that this "culture of silence" is what feeds into the frustration and anger of health care workers and often leads to health care workers themselves becoming perpetrators of abuse against patients.

The focus of the hypothesis was therefore about getting the clinic staff more involved and was formulated in the following way:

If the staff feel engaged and included in what we are doing as regards GBV

Then we are more likely to see staff who feel positive, willing and open to try out different kinds of action to bring down the levels of GBV

Because we will take up the following actions:

- The Core group will engage the staff in dialogues about GBV
- Staff will be invited to share their feelings and ideas for creating 0% GBV in the Meadowlands Clinic

On 19 May 2016 the Core Group facilitated a dialogue called the "Clinic Tea" with 63 representatives from different sections of the clinic staff. For the first time nurses, security guards and management were in the same space speaking about their experiences of violence in the clinic. The core group facilitated discussions at 8 different "tea tables" and staff were encouraged to chat informally about both the challenges they were experiencing but also to share ideas on how they could contribute to creating a clinic free of gender based violence. In the core group's assessment the "Clinic Tea" has helped to break the silence around gender based violence in the clinic.

Clinic Health Committees have come into existence with the promulgation of the National Health Act, 2003 and has the role of facilitating community participation in the health system.

Community participation is defined in the Alma Ata Declaration as:

The process by which individuals and families assume responsibility for their own health and welfare and that for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. (WHO, 1978)

What will it take to improve the relationship between patients and staff is the question the CHC set out to test. As members of the Meadowlands Community the Clinic Committee members were all too familiar with hearing stories of mistreatment and abuse from both patients and staff – yet they were hearing these stories in their individual capacity and not as the representatives of the CHC. The assumption being that patients and staff were not aware of the role of the CHC and that if the CHC was more visible and equipped to create safe dialogical spaces – patients and the broader community could explore less violent and more constructive options for working towards 0% GBV in the Meadowlands Clinic.

The hypothesis was framed as:
If we formally introduce the Clinic Health Committee and make visible the CHC's involvement in actions to reduce GBV

Then we will see:

- A Clinic Health Committee that does not exist in name only and is recognized as a structure that can facilitate collective problem solving and positive communication
- A Clinic Health Committee that lobby's and organizes for safe spaces for survivors of GBV
- A Clinic Health Committee that promotes the value and respect for care work

Because we will take up the following actions:

- Formally introduce the CHC to patients and staff and speak about as well as demonstrate our role as advocates for 0% GBV at the clinic.
- Advocate for quality of interpersonal communication between clinic staff and patients as both a right of the patient and of the clinic staff
- Play a visible role in all the community dialogues on reducing GBV – organized by the core group
- Network with NGO's, CBO's and Government Departments doing GBV preventative work and supporting survivors of GBV

Older patients with multiple chronic conditions form a significant percentage of the number of patients visiting the Meadowlands Clinic. When the core group was formed one of the older patients receiving chronic medication, Shadrack Sebusi joined and identified his role in the core group as a voice of the older patients attending the clinic. Shadrack is also an active member of a Wellness Club drawn from mostly older patients attending the Meadowlands Clinic. While the Wellness Group does attract some young people the majority are older patients and the focus of the Wellness Group is ageing and wellbeing. In Shadrack's account of the experience of the elderly attending the clinic, long waiting times, staff shortages and the attitude of staff were identified as the factors leading to older chronic patients feeling violated and at times responding angrily.

Statistics show that women are more likely than men to visit public health care facilities (Govender and Penn- Kekana, 2007) and the relatively larger numbers of older women attending the public health facility adds a further dynamic to the gendered nature of the cycle of abuse taking place in the health system. As elderly persons, both men and women are vulnerable to discrimination and exclusion, but for older women there is the added possibility of being survivors of domestic violence and having experienced discrimination in relation to education and employment. The stereotype of the older woman is the self-sacrificing grandmother who because she no longer has the ability to make babies is regarded as having less value when compared to men. For the elderly person and particularly the elderly woman, being treated with dignity and respect is at the heart of a positive health care experience.

Shadrack's hypothesis focused on exercise and wellbeing as a means of improving the health care experience for elderly women and men and creating a positive, affirming environment where particularly elderly women could feel equal to men. The question was framed as: **What will it take for women and men in the Wellness Club to relate as equals?**

If we create a safe space and encourage men and women to exercise together regularly while discussing their concerns about their medical conditions, the medication they are using, self-management strategies they employ and the benefits of exercise on their health

Then we will see elderly men and particularly elderly women patients more active in taking agency and responsibility for their health and more willing to engage constructively with clinic staff

Because we will take up the following actions:
Organize regular spaces for exercising and use our skills for encouraging dialogue that gives everyone an opportunity to share their feelings, experiences and suggestions

Physical infrastructure and adequate resources plays an important role in both staff and patient morale and impacts on relationships between staff and patients. For staff arriving to a facility that they are proud of and having access to tools essential for carrying out their work plays a huge role in how they feel and act in the workplace. Patients entering a facility that is clean, tidy and where the security guards are friendly, are more likely to engage positively when being attended to by health care workers. A health facility that the community and staff show pride in can also express an increase in the value being placed on health care work.

The core group's hypothesis on physical infrastructure had the following framing question: **What will it take to create a facility that both staff and patients are proud of**

If as different stakeholders i.e. the unions, the CHC, the patient groups, the clinic management collectively advocate for improved infrastructure and resources while collectively creating a culture of ownership and pride in the existing facility and resources

Then we will see all stakeholders directly involved in the clinic constructively engage in the improvement and maintenance of the clinic

Because we will take up the following actions:
- CHC monitoring and reporting to the clinic management on infrastructural challenges that needs to be addressed
- Union members negotiating with the Department of Health for resources that will improve services to patients
- CHC encourages patient groups to use the suggestion box in the clinic to identify challenges
- CHC encourages patients to identify what is working well
- CHC, unions and patient groups identify the kinds of facilities needed for supporting survivors of gender based violence

Engaging the broader community in creating 0% GBV in the Meadowlands Clinic has been a key component of the work of the core group. In illustrating the engagement with the broader community we are highlighting three examples of stakeholders in the community i.e. the South African Police Services; church; organizations working with young women and the community media. The core group developed hypothesis for these four forms of engagement.

What will it take to have the active involvement of the SAP's in the pilot project?
If we meet with relevant officers from the local police stations to share ideas on supporting survivors of GBV

Then we will see active examples of the police and health services working together to support survivors of GBV

Because we will take up the following actions:
- Invite the SAP's to participate in community dialogues where they will experience a safe non-judgmental space
- Include SAP's representation in the core group and create flexible enough meetings times that can accommodate police officers with many other competing priorities
- As stakeholders in the core group – play an active role in forums convened by the SAP's

What will it take for the churches in Meadowlands to work towards creating 0% GBV in the Meadowlands Clinic?
If we engage members of the church in dialogue about the levels of GBV in the church and how GBV manifests in the Meadowlands Clinic

Then we will see:
- More church members working from the platform of the church to break the silence about GBV
- Church members taking actions that contribute to creating 0% GBV in the clinic
- Church members supporting the advocacy role of the CHC in reducing the levels of GBV in the clinic

Because we will take up the following actions:

- Invite ministers from churches to be part of our community dialogues focused on creating 0% GBV in the clinic
- Use the churches as venues for community dialogues on GBV
- Support church ministers who are conducting services in the morning with patients at the clinic to include messages about creating 0% GBV in the clinic

What will it take for the Meadowlands Clinic to involve young women in the work of creating 0% GBV in the Meadowlands Clinic?
If we engage in dialogue with NGO's and CBO's working with young women - on the challenges they face when visiting health facilities like the Meadowlands Clinic and encourage them to share their ideas for creating a safe and supportive health facility for young women

Then we will see:

- More young women willing to work with structures like the CHC to create safe spaces and processes in the clinic for young women, especially for those who have experienced GBV
- More young women have a clearer understanding of some of the challenges facing clinic staff and are more open and confident to engage older clinic staff members
- Clinic staff members are less judgmental and more empathetic to the challenges and feelings of younger women visiting the clinic
- Clinic staff members take actions to create a safer environment for young women visiting the clinic

Because we will take up the following action:
The CHC to engage in inter-generational community dialogues with young women from NGOs like SADDAC, a youth based organization in Meadowlands and with young women who are part of the Action Aid initiated Young Urban Women's Program to shift from stereotyped ideas of the "irresponsible young women" and "uncaring nurse" – to a sharing of the common challenges facing both young and older women working in and visiting health facilities and developing collective actions for creating 0% GBV in the clinic.

What will it take for the community media to be part of contributing to 0% GBV in the Meadowlands Clinic?
If we invite young community journalists to be part of our community dialogues and encourage their participation in the core group meetings

Then we will see local media coverage of the positive actions different stakeholders are taking up in reducing the levels of GBV in the Meadowlands Clinic - because the local media reaches every household in Meadowlands - the community members will feel inspired to play a role in creating a Meadowlands Clinic free of GBV.

Because we will take up the following actions:

- Invite the community journalists be part of the stakeholders committed to working towards reducing the levels of GBV at the clinic
- Highlight the stories of community and stakeholder actions that are impacting on the levels of GBV at the clinic

One of the principles of the **Primary Health Care system** in South Africa is community participation. Community participation is understood as being central to individuals and communities being part of their own health decision making processes and having their experiences and views inform health care policy. In the context of the pilot project in Meadowlands the core group developed a hypothesis for involving the Department of Health in the community dialogues.

If we involve the Department of Health in the pilot project and invite representatives who are passionate about reducing the levels of GBV to be part of the core group
Then we will move from a confrontational "them" and "us" approach to a sharing of ideas and actions for reducing GBV in the health system

Because we will take up the following actions:

- Encourage Department of Health representatives participating in the pilot project to work with their power and authority as equal and not special partners in the collective action process
- Create safe spaces for dialogue where differences of opinion are encouraged as a means of strengthening the work
- Create an environment where every stakeholder's contribution is valued equally regardless of the level of resources they are able to contribute

MEASURING OUR RESULTS

For all of us involved in the Meadowlands Pilot Project, the past 2 years has been an important learning experience. As a facilitation team our starting assumption was that the establishment of the Meadowlands Clinic Core group made up of key stakeholders passionate about reducing the levels of GBV in the clinic – would be the engine of the process.

The core group's development of a set of hypothesis early on in the process assisted us to collectively identify the areas of action different individuals and stakeholders held close to their heart – while creating a common set of indicators to monitor our progress in moving towards 0% GBV in the Meadowlands Clinic.

Regular core group **reflection meetings** created the space for continuous learning where the group used the space to openly share information, observations and new learning. This is where strategies were adapted and changed.

An example of changing strategy: There was an assumption that young women's experience of GBV in the health facility would be heard in the community dialogues. Through ongoing reflection in core group meetings it became clear that the level of anger and frustration young women felt was not being heard and that to break this silence there was a need to create a safe space where the core group would focus on creating the atmosphere as well as use affirming and non-judgmental questions to help break the silence.

In December 2016, the core group met with a group of young women from the organizations Afrika Tikkun and SADDAC. The feedback from participants in the dialogue affirmed the Core Group's decision to create a specific dialogue with young women

"This discussion has really opened open my eyes about how young women are mistreated especially in relation to HIV and pregnancy. Nurses and doctors- see them as their own children. Nursing staff have been speaking about how they see the young women like their own kids and they worry about. From culture we learn that every child is my child – but while we can care we cannot be passing judgment and this is what I am learning from this discussion. (Meadowlands Clinic staff member)

The whole discussion was an eye opener and we did not see the defensive attitude I was expecting to see. It was like the nurses were coming down to our age". (Afrika Tikkun member)

"I can see how the problems are common and I can now see the perspective of the nurse. I would like the Department of Health to see what is happening and they must not just send down- protocols. I would like the contact details of everyone here so that we can continue this kind of discussion". (Afrika Tikkun member)

Between March 2015 and April 2017 the Core Group convened 5 community/stakeholder dialogues and 1 dialogue with clinic staff. Pre-event planning and post event reflection and evaluation process were held. Examples of questions in the reflection discussions:



What are we learning about the gendered nature of the violence being experienced in the health system?
What are we learning about the kinds of actions individuals and groups are taking up to address the levels of GBV in the health system?
Where, with who and how are we creating a more collective response to the levels of GBV?
What are we learning about reducing the levels of violence in the health system?

In the reflection meetings the core group spoke of their own experience of the dialogues – largely a subjective account of what they were seeing and hearing. Records of participant's comments and evaluations – helped to shape the discussion. With participant registers, core group members were also able to track who they were connecting with and used this as a means of inviting stakeholders to follow-up discussions.

By the middle of 2016 the core group decided that to get a better sense of impact they would need to hear voices beyond that of the core group. A short questionnaire was developed and three core group members conducted a focus group of 15 regular clinic patients. The focus group was randomly selected from patients at the clinic. An interesting observation from the patients in the focus group, was that while they could not explain how and who was responsible, they were experiencing a more peaceful and welcoming atmosphere in the clinic. Margaret Motau, a Clinic Health Committee member then further validated this observation by reporting in the Core Group that from the clinic suggestion box, the CHC was seeing an increase in positive responses from patients about the atmosphere in the clinic.

OUR KEY RESULTS

The key results identified below emerges from the Core Group's evaluation and reflection discussions, the focus group discussions and from 2 stakeholder engagements in October 2016 and April 2017 - where key stakeholders related to the health system were brought together to assess the impact of the pilot project.

- Representatives from the Region D District Health Forum are inspired by the way the Meadowlands Core group has demonstrated how the violence in the health system is gendered and the different kinds of actions that have been taken up to reduce the levels of GBV at the clinic. All of the 29 clinics in region D are now keen to initiate a similar project.
- Provincial Department of Health representatives at the stakeholder engagements are interested in partnering with the Core Group on taking forward the lessons of the pilot project.
- HOSPERSA is organizing similar initiatives in institutions where they are organizing.
- The Clinic Health Committee at the Meadowlands Clinic has broadened its mandate to include monitoring the levels of GBV in the clinic. This includes monitoring the service survivors of GBV are receiving; taking up actions to improve communication between staff and patients so as to reduce tension and to create an environment of care and wellbeing; monitoring and suggesting ways of improving the physical infrastructure and general functioning of the clinic so as to make the clinic a welcoming space for staff and patients and using available opportunities to affirm the care work health care workers are carrying out.
- Through the community dialogues, Meadowlands Clinic is being recognized as an institution that is willing to listen, learn from patients and the broader community and as an institution where survivors of GBV are treated with respect and dignity.
- The Meadowlands Clinic Pilot project has demonstrated that it is possible to bring different stakeholders together to plan, organize and take up actions towards the common goal of reducing the levels of GBV in the health system.

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